# UTAH STATE DEPARTMENT OF HEALTH
## CRIPPLED CHILDREN'S SECTION

### Application for Service

Name _____ Date of Birth _____

Address _____ City _____ County _____ Tel. No. _____

**History** (brief outline of presenting problem, including reason for referral to Crippled Children's Service):

**Physical Examination:**

General appearance: _____

_____

Head, EENT: _____

_____

Chest: _____

Lungs: _____

Heart: _____

Abdomen: _____

_____

Extremities: _____

_____

**Tentative Diagnosis:** _____

_____

Parent consent for referral to CCS:

We authorize the Crippled Children's Service to perform the necessary diagnostic examination, to recommend treatment, or to recommend and provide treatment for the above child.

Signature _____
Parent or Legal Guardian

Physician's request for referral to CCS:

Referral to Crippled Children's Service is requested by me for:

☐ Diagnostic consultation

☐ Diagnostic consultation and treatment (should the patient meet the eligibility requirements of CCS)

Signature _____ M. D.

Address _____

Date _____

Please send application to:

Utah State Department of Health
Crippled Children's Service
45 Fort Douglas Blvd.
(DA 2-2431)

Additional forms may be obtained at above address

The State of Utah
Department of Public Health

# INFECTIOUS HEPATITIS INVESTIGATION FORM

Date of Investigation:_____

Name of Suspect_____ Age_____ Sex_____ Race_____

Address_____ Telephone_____

School_____ Grade_____ Occupation_____

Attending Physician_____ Address_____

Date of Onset_____ Hospitalized: Yes ( ) No ( ) Where?_____

Diagnosis Confirmed by Physician: Yes ( ) No ( )

Description of Illness:

| | | | |
|---|---|---|---|
| Anorexia | ( ) | Fever | ( ) |
| Fatigue | ( ) | Max. Temp. | ( ) |
| Nausea | ( ) | Jaundice | ( ) |
| Vomiting | ( ) | Palpable Liver | ( ) |
| Diarrhea | ( ) | Treatment | ( ) |
| Headache | ( ) | Previous History of Jaundice | ( ) |
| Treatment_____ | | G.G._____ | |

FAMILY ROSTER:

| NAME | AGE | SEX | SCHOOL | GRADE | RELATION TO PAT. | ILL | PALPABLE LIVER | G.G. DOSE |
|---|---|---|---|---|---|---|---|---|
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| | | | | | | | | |

Source of Milk:_____ Source of Water:_____

Sewage Disposal: pit privy_____ Septic tank_____ Sewer connection: Yes ( ) No ( )

City Disposal: Sewage treatment: Yes ( ) No ( ) Site of Disposal_____

Contact with infected person: Yes ( ) No ( ) Name and address_____

Blood transfusion or Plasma during past 6 mos.: Date_____ Hospital_____

Vaccination during past 6 mos.: Date_____ Physician_____

"Shot" during past 6 mos.: Date_____ Physician_____

Contact with animals: Cows_____ Horses_____ Dogs_____ Fowl_____

Blood Drawn: (1) Date_____ (2) Date_____

Investigator_____ Date Completed_____

12/4/61 /jk